NHS
Sheffield
Clinical Commissioning Group

Minutes of the meeting of NHS Sheffield Clinical Commissioning Group Governing Body held in public on 6 February 2014 in the Boardroom, 722 Prince of Wales Road, Sheffield S9 4EU

A

Present:
Dr Tim Moorhead, CCG Chair, GP Locality Representative, West
Ian Atkinson, Accountable Officer
Dr Nikki Bates, GP Elected City-wide Representative
Kevin Clifford, Chief Nurse
Dr Richard Davidson, Secondary Care Doctor
Tim Furness, Director of Business Planning and Partnerships
Dr Anil Gill, GP Elected City-wide Representative (from item 28/14 onwards)
Idris Griffiths, Chief Operating Officer
Dr Andrew McGinty, GP Locality Representative, Hallam and South
Dr Zak McMurray, Joint Clinical Director
Julia Newton, Director of Finance
Dr Richard Oliver, Joint Clinical Director
Dr Marion Sloan, GP Elected City-wide Representative (from item 28/14 onwards)
Dr Leigh Sorsbie, GP Locality Representative, North
Dr Ted Turner, GP Elected City-wide Representative

In Attendance:
Sally Brown, Project Officer - Clinical Strategy, NHS England Local Area Team (for item 28/14)
Katrina Cleary, CCG Primary Care Programme Director
Rachel Dillon, Locality Manager, West
Professor Pam Enderby, Chair, Sheffield Healthwatch
Steve Hackett, Director of Finance, NHSE England Local Area Team (for item 2814)
Carol Henderson, Committee Administrator
Linda Tully, Company Secretary and Head of Corporate Governance
Dr Jeremy Wight, Sheffield Director of Public Health
Paul Wike, Locality Manager, Central

Members of the public:

10 members of the public were in attendance.
A list of members of the public who have attended CCG Governing Body meetings is held by the Company Secretary

23/14 Welcome

The Chair of the meeting welcomed members of the Sheffield Clinical Commissioning Group (CCG) Governing Body, those in attendance and observing, and members of the public to the meeting.

The Chair also welcomed Dr Nikki Bates, GP Elected City-wide Representative, to her first meeting.

24/14 Apologies for Absence

Apologies for absence had been received from Dr Amir Afzal, GP Locality Representative, Central, John Boyington, CBE, Lay Member, Amanda Forrest, Lay Member, and Professor Mark Gamsu, Lay Member.

Apologies for absence from those who were normally in attendance had been received from Helen Cawthorne, Locality Manager, Hallam and South, Dr Mark Durling, Chairman, Sheffield Local Medical Committee, Simon Kirby, Locality Manager, North, and Richard Webb, Executive Director – Communities

25/14 Declarations of Interest

There were no declarations of interest this month.

The full Governing Body Register of Interest is available at: http://www.sheffieldccg.nhs.uk/Downloads/CCG%20Board%20Papers/Feb%202014%20Board%20Papers/CCG%20Dec%20of%20Interest%20revised%2025%20February%202014.doc

26/14 Minutes of the CCG Governing Body meeting held in public on 9 January 2014

The minutes of the Governing Body meeting held in public on 9 January 2014 were agreed as a true and correct record and were signed by the Chair.

The Chair drew members' attention to Appendix A, detailing questions that had been submitted before the meeting and the CCG's responses to these, which had been posted following the meeting.

27/14 Matters arising from the minutes of the meeting held in public on 9 January 2014

a) Development of CCG Commissioning Intentions for 2013/14 (minutes 126/13(a), 151/13(a), 205/13(a), 231/13(a), 256/13(a), 05/14 refer)

The Director of Business Planning and Partnerships advised members that he had received a copy of a legal opinion that NHS England had obtained from Capsticks Solicitors LLP as to whether they had responsibility for commissioning hepatitis screening for the Roma Slovak population. Capsticks were of the view that NHS England does not have responsibility, but were not explicit as to who does. He would discuss this further with Sheffield City Council and Public Health England and report a final position to Governing Body. **TF**

b) Finance Report (minutes 265/13, 05/14(f), 12/14 refer)

The Chief Operating Officer advised members that the high level

proposals for the £2.883m winter pressures funds had been discussed at the Urgent Care Working Group and most were either now being implemented or in the process of being implemented. However, there were still some pressures around A&E.

c) Primary Care Enhanced Services Review (minute 09/14 refers)

The CCG Primary Care Programme Director confirmed that an Equality Impact Assessment would take place as we continue into the next financial year.

d) Month 8 Quality and Outcomes Report: Health Inequalities (minute 13/14(d)(i) refers)

The Chief Operating Officer reported that Susan Hird, Consultant in Public Health, had advised him that she was looking to produce appropriately timed reports on health outcomes that would be reported to Governing Body.

e) Quality Assurance Committee: Safeguarding (minute 14/14(d) refers)

The Chief Nurse confirmed that the role of Governing Body in safeguarding would be included in the Governing Body's June development session.

Dr Gill and Dr Sloan joined the meeting at this stage.

28/14 South Yorkshire and Bassetlaw Commissioners' Draft Joint Primary Care Strategy

Sally Brown, Project Officer - Clinical Strategy, and Steve Hackett, Director of Finance, NHS England, attended for this item. Mr Hackett presented this report. He advised members that NHS England has recognised that good quality primary care is the centre of the system to delivering good quality outcomes for the population, and the desire was to set a five year strategy to drive this forward. In the summer of 2013 they had launched a consultation and engagement exercise entitled Call to Action, which had a specific primary care element, and a bespoke piece of engagement work on Call to Action – Community Pharmacy, which would be fed into the final strategy. They were working with all five CCGs to pull together the common threads, and the CCG Programme Director was helping to pull some of the work together.

Mr Hackett reported that Information Technology (IT) is seen as a significant enabler. Recruitment of a quality workforce is also a significant aspiration.

Next steps include seeking further feedback from Governing Body and members of the population. The cover report gives a number of timescales, including feedback on the strategy between March and April.

The Chair commented that as hospital care was becoming increasingly unaffordable, this was a key driver for change to move services into the community, which must involve primary care, but he did not feel this was reflected in the draft. He also asked that we go beyond thinking about primary care contracts as they are now.

Mr Hackett agreed about the need for transformation but warned of difficulties around finance, and was happy to reflect this in the strategy.

The CCG Primary Care Programme Director recognised the need for a high level strategy and explained that there originally had been specific local sections within the strategy covering each CCG's high level aspirations that had resulted in duplication across the areas and so had been removed. It had also included the role of the commissioner in provider development, and thought needed to be given as to whether this was re-inserted.

Professor Enderby was pleased to see that comments that Healthwatch received from patients and members of the public relating to primary care had been reflected in the draft. However, there was no mention of the promotion of health, and nothing in the local demographics on birth rate and the student population. Also, primary care was wider than doctors, dentists and pharmacists and the strategy needed to reflect the wider workforce and other health professionals. Mr Hackett responded that he was happy to strengthen these points.

Dr Sorsbie asked about the scope for addressing local needs and if there was any scope for contracts being negotiated at a local level. Mr Hackett responded that there were nationally defined contracts at this point in time, but there was commissioning variation in individual practices depending on the needs of the population they serve, and he was currently in discussions with CCGs as to the opportunities for a co-commissioning model.

The Director of Public Health commented that whilst he was pleased to see the draft, he was underwhelmed as it did not seem to lay out a clear picture of what primary care will look like once the strategy is implemented. He would also like to see the role of primary care in tackling health inequalities and what this means, and would be pleased to facilitate a conversation with the Directors of Public Health across South Yorkshire as he felt they had not been part of the conversation.

The Chief Nurse commented what whilst he was pleased to see that workforce had been included, it was disappointing that research participation had not, and would be interested to see how this would be addressed and how it would be supported by the Area Team.

Dr Turner commented that issues relating to patient access to primary care seemed to have been captured, and he reported that patients and members of the public were very much aware of the pressure on primary care, on eating healthily, and on self care. It was important that primary care has the resources to promote health care.

Mr Hackett advised members that the CCG leads and the Area Team were taking forward some work in each area around consultation with members of the public and Health and Wellbeing Boards as part of Call to Action, as the strategy needs to be co-produced, and will include looking at different models in different areas..

Dr Oliver asked if a global point could be included stating that it could not sit in isolation from any other plans in the health economy.
Mr Hackett responded that the number of strategies across South Yorkshire and Bassetlaw was a debating point but that this one could not sit alone from any other health strategy and could not be looked at in isolation.

The Accountable Officer raised the issue of unintended consequences and asked that NHS England were mindful of their QIPP and ensuring that, as commissioning partners and in line with the strategy, they ensured that plans were tested with CCGs to avoid passing any financial burden to partners.

Governing Body requested that a further draft be presented to them in May, before making their final consideration in June.

29/14 Chair's Report

The Chair presented this report and offered to expand on any issues if members so wished.

The Governing Body received and noted the report.

30/14 Accountable Officer's Report

The Accountable Officer presented this report.

The Governing Body received and noted the report.

31/14 Commissioning for Outcomes for Musculoskeletal (MSK) Care in Sheffield

Dr McMurray, Joint Clinical Director, presented this report. He reminded members that they had previously agreed to mobilise discussions with the Sheffield Teaching Hospitals NHS Foundation Trust (STHFT), the current main provider, to test out whether a partnership approach was feasible as a new model and capable of delivering the desired outcomes for the CCG. He reported that discussions with the trust had been positive, with a lot of innovation around the system that had provided us with a sense of security. The project team was now formally asking Governing Body for approval to commence clinical discussions with the trust to develop the new service model, which would include engagement with members of the public, patients and other partners.

Professor Enderby asked a related question about the under spend reported on community MSK services for this financial year in the finance report. The Director of Finance explained this was because the

providers had not achieved all the KPIs in the contract and under the terms of the contract the CCG was withholding these sums. The Joint Clinical Director explained that he hoped that the proposed clinically-led service redesign would deliver better outcomes.

In response to a query, the Director of Finance advised members that it was intended that the service would be implemented from April 2015,

The Governing Body:

- Received and noted the report
- Agreed to the project team commencing clinical discussions to develop the new service model with STHFT.

32/14 Organisational Development (OD) Quarterly Update

The Company Secretary presented the first of the quarterly reports, which summarised the CCG's approach to developing the CCG as an organisation that is fit for purpose and highlighted some of the more substantive programmes currently underway.,.

The Governing Body:

- Received and noted the report.
- Was assured that the CCG was continually assessing and addressing its OD requirements to ensure the organisation was fit for purpose.

33/14 Finance Report

The Director of Finance presented this paper reporting the financial position to the end of December 2013, an assessment of the remaining key risks to deliver the forecast year end surplus. She advised Governing Body that there were no material changes since the last report. She reported that the two key pressures for quarter 4 were the level of acute hospital activity depending on the impact of winter and our agreed resilience measures with the trusts and secondly prescribing. She alerted members to a high risk of an increase in spend in Q4 as volumes continue to be high which had not been factored into the reported position but that existing contingency reserves should prove sufficient to cover. So in summary, she advised that the CCG was still on track to deliver the forecast year end surplus of £6.9m, which NHS England had recently confirmed could be carried forward in full into 2014/15.

With regard to delivery of the cash position, she advised members that further work was needed with NHS England to agree a final level of cash for the year which would allow the CCG to meet its payments requirements.

The Director of Finance then presented a high level summary of the CCG's financial planning for the next five years. She highlighted the information on the CCG's allocations for 2014/15 and 2015/16 (Appendix A) and an overview of the possible increases in funding in

the next five years and how this might be deployed in head line terms (Appendix B). She confirmed that further details would be included in the Commissioning Intentions to be published shortly.

She reported that the CCG's running cost allocation had just been received, which was just under £14m for 2014/15 (ie very close to 2013/14) and with the expected 10% reduction in 2015/16.

She reported that the CCG remained on track to submit a financial plan to NHS England by 14 February using the assumptions previously signed off by Governing Body in private in January.

She would present further information to Governing Body in March or April on how the plan would support our strategic intention to undertake more care in community settings. **JN**

The Governing Body:

- Noted the Month 9 financial position and forecast outturn position.
- Approved the budget changes highlighted in section 4 of the report.
- Noted the progress to date to complete a plan which meets national requirements and can underpin delivery of the CCG's Commissioning Intentions and strategic vision.

34/14 Month 9 Quality and Outcomes Report

The Chief Operating Officer presented this report which reflected the CCG's statutory responsibilities. He reported that despite some of the pressures, we remained in a favourable position as a health community, with a reasonable level of stability in terms of outcomes and reporting, presented the key performance issues and drew members' attention to the following key highlights.

a) Quality Innovation, Productivity and Prevention (QIPP) programme

Continuing Healthcare and medicines management continued to perform well in terms of savings. Urgent care has struggled in some activities, however, long stays in hospital have significantly reduced this year, the urgent primary care centre pilot is currently being implemented. Elective care has seen high levels of activity, and with continued GP involvement improvements will be seen as clinical pathways are developed.

b) Waiting Times and Access to Diagnostic Tests

There were 58 patients waiting over six weeks, however, we recognise that there are particular capacity issues at Sheffield Teaching Hospitals NHS Foundation Trust (STHFT), which we hope will be quickly addressed.

c) Ambulance and Crew Response Time

Following the request at January Governing Body, more information was included about ambulance crew turnaround times, with more

information from the Yorkshire Ambulance Service NHS Trust (YAS) still to be reflected in the report. He reported that in only one instance the delay in turnaround was due to a shortage of hospital beds. He would keep Governing Body updated as further information becomes available.

d) A&E Waiting Times

Although performance had been gradually improving for a couple of months, it had slipped back from 95.6% to 95.48%. There were a significant number of patients coming through A&E and, for the first time this calendar year, there had been four consecutive days with 400 people attending. The level of Norovirus at the Northern General Hospital (NGH) site was an added pressure on bed availability of beds. As a result, this week we have instigated a daily teleconference across health and social care at Director and Deputy Director level to facilitate rapid discharge, which was working well.

The Chair commented that it was disappointing to hear about this performance, given the local investments we had identified before winter set. The Chief Operating Officer responded that the additional £2m of national monies put into the system, had reduced our spend, but part of this was due to the complexity of the system and knowing where to put in the additional capacity. We needed to review whether putting money in to increase the capacity was the right thing to do.

e) Reduction in Emergency Admissions for Children with Lower Respiratory Tract Infections (LRTI)

The Chair commented that the data showed a deterioration in performance since last month. The Chief Operating Officer was asked to review this performance data and update Governing Body in March. **IG**

f) Mental Health, Learning Disabilities and Dementia

Dr Oliver, Joint Clinical Director, asked Governing Body to note the very positive comments included in the summary position at page 3 of the report, which implied that the system was working more efficiently.

g) Quality

The Chief Nurse reported that there was little in terms of trend change to report since last month.

The Governing Body:

- Noted how Sheffield CCG compares to other similar CCGs on key areas of Health Outcomes.
- Noted Sheffield performance on delivery of the NHS Constitution Rights and Pledges.
- Noted the key issues relating to quality, safety and patient experience.
- Noted the initial assessment against measures relating to the Quality Premium.

35/14 Quality Assurance Committee (QAC)

Serious Incident (SIs) Reports

The Chief Nurse presented two reports which provided updates on new SIs in Quarter 3 and December 2013. He advised members that Sheffield Health and Social Care NHS Foundation Trust has a challenging rule set for reporting and we were working with them to reduce their number of SIs and the backlog of reports.

He welcomed feedback from members on any improvements they felt could be made to future reporting.

The Governing Body:

- Received and noted the Quarter 3 and December 2013 reports.
- Supported the development of devised data reporting.

36/14 Updates from the Locality Executive Groups (LEGs)

a) Central

The Locality Manager reported that the same day appointment sessions in Central, funded by the winter pressures monies, had been running since 4 December and had seen over 600 patients during this time. The locality was also focusing on expansion of the integrated care teams, an expression of interest for the Prime Minister's extended access funding, which has to be submitted by 14 February, and service redesign around respiratory services, for which they would be presenting a business case to the CCG. He also reported that the district nurses had met earlier in the day and it had been agreed that all practices across the city would have a named district nurse link.

b) HASL

Dr McGinty advised members that Helen Cawthorne, recently appointed Locality Manager, was in the process of meeting with all practices on an individual basis. He also advised members that an Extraordinary meeting of the LEG would take place the following week to discuss how they could increase engagement from practices.

c) North

Dr Sorbsie advised members that. The pilot for screening members of the Roma Slovak population had been running since January and would be evaluated. A pilot was being run in the locality to identify issues around access to services for learning disabilities

d) West

The Locality Manager reported that the locality's focus was to have sufficient information and support to undertake care planning. The locality has now appointed a practice nurse to work with them for a year on CCG and city-wide projects, the role would act as a conduit and to

shared learning with other practice nurses, and would be setting up a group to actively engage nurses.

The Governing Body noted the reports.

37/14 Reports for Noting

The Governing Body received and noted the following reports:

- 2013/14 Business Plan Quarterly Exception Report

  The Director of Business Planning and Partnerships advised members that the testing of the plan by the Planning and Delivery Group was very rigorous and seemed to be paying dividends as the Auditors had not raised any particular concerns about it at the governance Sub Committee that had been held the previous day.
- Key highlights from Commissioning Executive Team and Planning and Delivery Group meetings.

38/14 Questions from the Public

A member of the public had submitted a number of questions prior to the meeting. The CCG's responses to these are attached at Appendix A.

39/14 Confidential Session

The Governing Body resolved that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest, section (2) Public Bodies (Admission to Meetings) Act 1960.

40/14 Any Other Business

There was no further business to discuss this month.

41/14 Date and Time of Next Meeting

Thursday 6 March 2014, 2.00 pm, Boardroom, 722 Prince of Wales Road, Sheffield S9 4EU

Appendix A

Questions from Mike Simpkin, Sheffield Save Our NHS, questions to the Governing Body 6 February 2014

Question 1: GP surgery: Patient Participation Groups are not mentioned in the main report or Appendix 2 although at the top of p15 there is reference to something called the patient participation enhanced service. Does the CCG consider that PPGs may have an important role to play in its engagement activity (including information about this strategy) and if so, does it have any plans to support their further development? Will the CCG consider affiliation to the National Association for Patient Participation if it has not already done so or seek advice from Sheffield General Practices which are affiliated?

CCG Response: *Yes, we do think that practices' patient participation groups may have a role to play, but we recognise that their primary purpose is to influence practices' decisions about their own services, and would not want to undermine that important purpose. It is more likely that we will use PPGs as a way of connecting to people we can see are interested in being more involved, to offer them the opportunity to join the CCG list of interested people who we will seek to involve, rather than making PPGs a formal part of our participation structures, but this is still under discussion. We have not formally considered affiliation to the National Association for Patient Participation, but at first sight it would appear more appropriate for practices to affiliate.*

Question 2: What does the CCG consider to be the likely effect on NHS services in Sheffield of General Practices being able to accept non home visit patients from outside their boundaries?

CCG Response*: This is a contractual matter between NHS England and each practice and we will not know the degree of practice sign-up for this initiative until the next financial year.*

Question 3: Care Data: The government information leaflet about the uploading and centralisation of patient confidential records from general practices was delivered to households as junk mail, and one (non scientific) survey has suggested that 40% of doctors may opt out. Whatever the advantages of the care data scheme from a clinical research and management perspective, does the CCG consider that enough has been done to make people in Sheffield aware that unless they opt out their personal medical data will be uploaded in identifiable format before pseudonymisation and that in some circumstances their full records may be accessed by and sold to approved private sector organisations without their specific consent. Is this not a major risk to trust in the patient-doctor relationship and in the NHS itself?

CCG Response: *The national care.data project has been delayed by 6 months following national concern about appropriate public awareness. The NHS England website posted the following on 19 February 2014:*

“To ensure that the concerns of the BMA, RCGP, Healthwatch and other groups are met, NHS England will:

- *Begin collecting data from GP surgeries in the Autumn, instead of April, to allow more time to build understanding of the benefits of using the information, what safeguards are in place, and how people can opt out if they choose to;*
- *Work with patients and professional groups – including the BMA, RCGP and Healthwatch – to develop additional practical steps to promote awareness with patients and the public, and ensure information is accessible and reaches all sections of the community, including people with disabilities;*
- *Look into further measures that could be taken to build public confidence, in particular steps relating to scrutiny of ways in which the information will be used to benefit NHS patients”*

The following is a quote from Tim Kelsey, national director for patients and information at NHS England:

“NHS England exists for patients and we are determined to listen to what they tell us. We have been told very clearly that patients need more time to learn about the benefits of sharing information and their right to object to their information being shared. That is why we are extending the public awareness campaign by an extra six months.”